CROWSON

v

LAROWE

DR. JUDD LAROWE

June 06, 2018

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IN THE UNITED STATES DISTRICT COURT

CENTRAL DIVISION

MARTIN CROWSON,

Plaintiff,

vs.

JUDD LAROWE, BRET LYMAN, et al.,

Defendant.

Case No. 2:15-CV-880-RJS

Judge Tena Campbell

DEPOSITION OF DR. JUDD LAROWE

Taken at the Courtyard Marriott
185 South 1470 East
St. George, Utah

On Wednesday, June 6, 2018
At 9:03 A.M.

Reported by: J. Elizabeth Robison, RPR, CCR

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James Kenner

EXAMINATION INDEX

P R O C E E D I N G S

* * *

DR. JUDD LAROWE,

having been first duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

-oOo-

EXAMINATION

BY MR. SCHRIEVER:

Q. Dr. LaRowe, my name is Ryan Schriever. I represent an inmate by the name of Martin Crowson. Do you know Mr. Crowson?

A. I do not.

Q. Okay. We are here to take your deposition today.

Have you ever had a deposition taken before?

A. Once, a number of years ago. I'm not even sure when.

Q. Okay. What did that case involve?

A. I was asked to be an expert witness in a case where a patient had been on Coumadin and things went awry.

Q. Okay.

A. So...

Q. All right. And that was a number of years ago?

A. It was. Probably at least a decade.

Q. Okay. Well, by way of refresher, then -- and I know you've had a chance to talk to Mr. McGarry, who is an excellent attorney -- but the deposition is our chance to just find out what you would be able to testify to if we were to get to trial. So you're under oath. It's the same as being in trial, except there's no judge here. There's no jury, and we're given a little bit more, latitude to just find out things about the case.

So I'm going to ask you things about your background, qualifications, what you do with the Department of Corrections, what your practice is, and then any knowledge or memory you have of the specific events related to this case.

Does that make sense?

A. Yes, it does.

Q. Okay. You're answering audibly, which is exactly what we need you to do, because we are making a transcript of the deposition. And a lot of times in conversation we have speech patterns that make it really casual, like saying "uh-huh" or "huh-uh." And that requires our court reporter to

make -- to interpret what you're saying. So if you don't say "yes" or "no" to a yes-or-no question, I might remind you just to say "yes" or "no."

A. That would be fine.

Q. Okay.

A. Thank you.

Q. All right. We also -- I don't anticipate that we'll be too long. But if you want to take a break at any point, we can do that.

A. Thank you.

Q. And if I ask you a question that you don't know the answer to or you don't remember, you can tell me that you don't know or you don't remember. That -- those are fine answers. I may probe around the edges to see if we can jog your memory. But I -- we need to know what your knowledge is, what your firsthand knowledge is.

Does that make sense?

A. Yes, it does.

Q. Thank you.

Well, to get started, would you please state your name for the record?

A. My name is Judd LaRowe.

Q. Okay. And LaRowe is spelled -- how do you spell LaRowe?

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withdrawal symptoms from heroin similar to what they are from methamphetamine?
MR. MCGARRY: Object as to form.
A. The withdrawal symptoms to heroin, once again, very nonspecific: Nausea, diaphoresis, tachycardia, tachypnea, elevated blood pressure. And those might last longer than methamphetamine. The half-life for heroin is going to be a little longer.
Q. Okay. And when you say a little bit longer, what's the time period, do you think?
A. I don't know. I couldn't give you a precise opinion on that.
Q. What about alcohol withdrawal symptoms?
A. They can last longer. Usually, the time of onset is within 72 hours of cessation. But especially when you're talking about delirium tremens, that can go on for days and days.
Q. Can it go on for weeks?
A. Not weeks.
Q. Can it start weeks after?
A. No, it cannot.
Q. And by "delirium tremens," what do you mean by that?
A. The DTs, the typical symptoms: Visual

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hallucinations, auditory hallucinations, tactile. I won't call them hallucinations. But you can have odd tactile sensations, confusion, agitation. And then pretty much the same symptoms as we've discussed with the others.
Q. Would not knowing what kind of work you had done prior to incarceration be a delirium tremens?
A. That's a pretty --
MR. MCGARRY: Object to form.
A. -- nonspecific --
MR. MCGARRY: Sorry, Judd.
A. Oh.
MR. MCGARRY: Object to form. Go ahead.
A. Okay. That's a pretty nonspecific complaint. So that could be part of that.
Q. Okay. Do you recall receiving any information from Mike Johnson that's not contained in these notes?
A. I don't.
Q. As you reviewed these notes, did you see anything in there that you thought would be specific, as it relates to a delirium tremens?
A. No, I did not. These symptoms are nonspecific. There are a lot of different disease

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states that these could be present in.
Q. Are they consistent with encephalopathy?
A. They could be.
Q. Now, you reviewed the records from Dixie Regional Medical Center; is that correct?
A. I did.
Q. Did you agree with the diagnosis of toxic metabolic encephalopathy?
MR. MYLAR: Objection. Lack of found -- lack of foundation.
A. Without examining the patient, and just based on my review of the records, I would agree. That's a pretty nonspecific clinical diagnosis, so it would cover a broad range of possibilities. And it would be an appropriate diagnosis from what I reviewed.
Q. Okay. Did -- having reviewed those records from Dixie Regional Medical Center, do you have an opinion as to what Mr. Crowson's condition or diagnosis would have been during the time he was in Purgatory jail?
MR. MYLAR: Objection. Lack of foundation.
MR. MCGARRY: Join. Go ahead.
A. Would you restate that, please?

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Q. I will try. I -- that's a fair -- that's a fair request that I try to restate that.
Given all the information you reviewed, which I believe -- well, let's see here.
All the information you reviewed is the CorEMR notes and the Dixie Regional Medical Center notes; correct?
A. Correct.
Q. You haven't reviewed anything outside of those?
A. I have not.
Q. Okay. So having reviewed those records, do you have an opinion as to what the appropriate diagnosis for Mr. Crowson was, during the time he was in Purgatory jail, from 6-25-2014 to 7-1-2014?
A. Yes, I do.
Q. What's that?
A. Well, fortunately, I have 20/20 hindsight, and I can say it would be metabolic encephalopathy.
Q. Okay. When you are diagnosing a patient with metabolic encephalopathy, what are the symptoms that you're looking for?
A. Confusion is one of the large ones. There also is a physical finding called asterixis, which is very typical if you're dealing with hepatic

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encephalopathy. Specifically, there is a finding of fetor hepaticus. The breath smells fruity, yeah, oftentimes in these individuals. Sometimes there will be jaundice. They can be quite agitated as well. But once again, those fall under many subheadings. But those are the things you might typically see in that case.

Q. Okay. If you suspect that somebody has metabolic encephalopathy, what's the appropriate course of treatment?

A. The appropriate course of treatment in that case, several things. One, you treat the agitation. Number two, you also would give them either neomycin or lactulose. Those help reduce ammonia levels. Typically, you'd give them thiamine, because anyone with hepatic encephalopathy is usually thiamine deficient. They're also usually deficient in other vitamins, so we typically give them a multi-vitamin. We give them thiamine. You would treat them with lactulose or neomycin. You would treat their agitation as well. You know, those are the main things --

Q. Okay.

A. -- that you would use.

Q. What diagnostic tools do you have

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available to you to diagnose metabolic encephalopathy?

A. Once again, the blood work. You can sometimes get a clue. If the acid base balance is out of the norm, that can be reflected in a comprehensive metabolic panel. An arterial blood gas would also tell you some of those items. An ammonia level. Although, an ammonia level needs to be drawn arterially to get the best product. So an arterial draw is something that generally only takes place in the hospital.

Q. Okay. How about an MRI?

A. I would not say that that's useful.

Q. Okay. How soon should a person be treated when they have metabolic encephalopathy?

MR. MCGARRY: Object to form.

A. You would like to treat that person when you first realize that that's what's going on.

Q. Why is that?

A. Quicker recovery.

Q. Okay. Can encephalopathy cause permanent damage?

MR. MCGARRY: Object to the form.

MR. MYLAR: Object. Also --

A. Permanent?

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MR. MYLAR: -- lack of foundation.

Q. Permanent injury to the brain?

MR. MCGARRY: Same objections.

MR. MYLAR: Same objection.

A. On that, I -- I'm not sure I can speak to that. I don't believe so.

Q. If a patient has encephalopathy, it wouldn't be appropriate to wait seven or eight days to treat them, would it?

MR. MCGARRY: Object to form. Foundation. Speculation.

MR. MYLAR: I join on those objections.

MR. MCGARRY: You may answer. Sorry.

THE WITNESS: Okay. Oh.

MR. MCGARRY: You were waiting for me to add some more?

THE WITNESS: Yes, I was.

MR. MCGARRY: Incomplete hypothetical. Sorry. If you want to critique my lawyering, just feel free, Doctor.

THE WITNESS: Am I paying you hourly?

MR. MCGARRY: Apparently, you're not getting your money's worth maybe.

THE WITNESS: Once again, could you restate the question?

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MR. SCHRIEVER: Yeah. Well, in fact, why don't we just have it read back. Then the objections are on the record.

THE WITNESS: All right. Thank you.

(Question read by the reporter.)

THE WITNESS: No. You would want to treat the patient as soon as you realize what the diagnosis is.

MR. SCHRIEVER:

Q. All right. Now, I'll represent to you, Dr. LaRowe, that when I -- when we deposed Ryan Borrowman --

A. Yes.

Q. -- I'll -- I'm paraphrasing, obviously. So we'll just note the objection on the record already.

He didn't have any difficulty identifying Mr. Crowson's symptoms as serious enough to recommend to you that Mr. Crowson be transported?

A. Correct.

Q. Did anything Mr. Johnson ever tell you give you an indication that he -- that Mr. Johnson thought Mr. Crowson's symptoms were significant enough to be transported?

A. No. And our policy -- and I -- the

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nursing staff and myself are all on board with this -- is: You know, the patient comes first. Whatever we need to do to make sure we protect the patient. So no. If Mike had felt that the patient needed to be transported or thought there was even a question, we would have transported him at that time.

Q. Okay.

A. I'm not going to keep someone in the jail when the appropriate course of action is to have them seen in the emergency room.

Q. Which makes your ability to rely on Mr. Johnson critical; isn't that true?

A. It does. It does.

Q. Outside of the -- I know you don't keep notes of -- or records outside the jail.

Do you have any procedures or protocols for following up on patients, who you know have been having some sort of symptoms, like being dazed and confused?

MR. MCGARRY: Let me just ask for a clarification.

MR. SCHRIEVER: Yeah.

MR. MCGARRY: You mean -- so a patient who is still an inmate, when you say "following up,"

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not somebody who's been transferred to the emergency department or been released from the jail, but is sill incarcerated?

MR. SCHRIEVER: Correct, and I can make it more specific.

Q. For example, in this case, Mr. Johnson -- the records indicate that he contacted you on June 28th.

Do you have any kind of tickler system or policies or procedures where on June 29th you would call and say, "Hey, what's going on with Inmate Crowson?"

A. I don't. Mr. Crowson was transported to booking or moved from wherever he was before to the booking area, which is immediately adjacent to medical. And when they are moved to booking, medical will do rounds on them every shift, and I believe the deputies check on them every 30 minutes. And so there's pretty close observation. So that ensures good follow-up. And then if something occurs during their rounds or if they're notified by a deputy, they would give me a call.

Q. Okay. Now, I'm not necessarily familiar with hospital protocol or the way hospitals work.

But you have worked in a hospital; right?

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A. Correct.

Q. When you have patients under your care in a hospital, is there a -- is there a time period in which the doctor is going to say, "All right. I need to check up on this patient," or is there -- how did that work?

MR. MCGARRY: Object to form. Incomplete hypothetical.

MR. MYLAR: Join.

A. In a hospitalized patient, you would round on them daily. That's a minimum.

Q. Okay. And that's the doctor is going to round on them daily?

A. Correct.

Q. And then the nurses are there in addition to that; right?

A. Correct.

Q. In the jail system, that's different?

A. It's not a hospital.

Q. Right. But the purpose of putting him in booking was so that he could be under observation; right?

A. Correct.

Q. And so the nurses are there checking on him once per shift at a minimum?

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A. I believe so, yes.

Q. Okay. But there's no procedure for a doctor or a nurse practitioner or a physician's assistant to round on those inmates daily; correct?

A. No. There is no provision for that.

Q. Okay. Okay. On June 29th, 2014, the note from 7:48 A.M. indicates a heart rate elevated at 140. And again, there's a note here that says, "Staffed patient status with MD."

Do you recall having a second call with Mr. Johnson on June 29th?

A. I did recall, after reading the notes, yes. And then it -- I did re -- recall that, yes.

Q. Okay. And this protocol is Ativan two milligrams IM. What does that mean?

A. Intromuscularly.

Q. Okay. Means give a shot?

A. Yes, it does.

Q. Why Ativan at that point?

A. Ativan has a rapid onset, so I was hoping we'd get a quick response for him. And you know, his symptoms at that time with the agitation, I thought the benzodiazepine would help.

Q. And that's for the liver, the benzodiazepine; correct?